

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-026091

042

1000

865

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JUL 30 1962

1. PLACE OF DEATH

a. COUNTY

Buchanan

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Joseph

Length of stay in 1b

44 yrs.

c. FULL NAME OF (IF NOT in hospital, give location)

St. Joseph State Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Buchanan

c. CITY

OR

TOWN

St. Joseph

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

842 South 19th St.

Reside on Farm

Yes ☒ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Ezra

Bert

Chaney

4. DATE OF DEATH

Month

Day

Year

July

23

1962

5. SEX

M

6. COLOR OR RACE

White

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

11/28/1886

9. AGE (last birthday)

75

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Foreman

10b. KIND OF BUSINESS OR INDUSTRY

Western Dairy

11. BIRTHPLACE (City and state or country)

Owen County, Indiana

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Henry Finch Chaney

13b. MOTHER'S MAIDEN NAME

Johanna Hauser

14. NAME OF HUSBAND OR WIFE

Boulah T. Chaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

State Hospital Records, St. Joseph, Mo.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerosis

DUE TO (b) General Debility

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐SUICIDE ☐HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 7-21-62

to 7-23-62

and last saw him alive on 7-23-62

Death occurred at 12:15 PM

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

State Hospital, St. Joseph, Mo.

22c. DATE SIGNED

7-23-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

July 25, 1962

23c. NAME OF CEMETERY OR CREMATORY

Memorial Park

23d. LOCATION (City, town, or county)

St. Joseph

(State)

Mo.

24. FUNERAL DIRECTOR

Heaton-Brown

ADDRESS

St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG.

July 26, 1962

26. REGISTRAR'S SIGNATURE

Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm A Smith

Licensed Embalmer No. 3928

P. O. Address St Joseph mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.